Senate Budget and Fiscal Review—Wesley Chesbro, Chair

SUBCOMMITTEE NO. 3 Agenda
Health & Human Services

Chair, Senator Denise Ducheny

Senator George Runner
Senator Tom Torlakson

April 25, 2005

9:00 AM

Room 4203

(Diane Van Maren)

Item	Department
4280	Managed Risk Medical Insurance Board—*Selected Issues*
4260	Department of Health Services—*Selected Issues*

PLEASE NOTE: Only those items contained in this agenda will be discussed at this hearing. Additional issues regarding these departments will also be discussed at future hearings. *Please* see the Senate File for dates and times of subsequent hearings.

Issues will be discussed in the order as noted in the Agenda unless otherwise directed by the Chair. Thank you.

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A. ITEMS FOR VOTE ONLY—Department of Health Services

1. Medical Marijuana Identification Card Program

Issue: The budget proposes an increase of $489,000 (Medical Marijuana Program Fund) to continue with implementation of SB 320 (Vasconcellos), Statutes of 2003, whose purpose is to establish and maintain a voluntary medical marijuana identification card and registry program. If this increase is approved, a total of $1.2 million (Medical Marijuana Program Fund) would be budgeted for 2005-06. Current year expenditures are anticipated to be about $1.1 million (Medical Marijuana Program Fund).

Of the $489,000 requested, $355,000 is related to card production (about $3 per card), $98,000 is for communication functions and the remaining $36,000 is for various activities, such as internet access and supplies.

The DHS received authorization to borrow up to $1.5 million from the Health Statistics Fund to commence with implementation of SB 420. This amount was transferred to the Medical Marijuana Program Fund and was to account for the first 18 months of program implementation. It was anticipated that this funding level would sustain the program until fees collected from card users began to flow to offset program costs and to repay the loan. According to the DHS, fees will begin to be collected in 2005.

A few aspects of implementation have changed since last year. First, some additional expenditures have been identified since the original implementation commenced, including the purchasing of card stock, card mailing costs, and travel expenditures to counties to assist with implementation.

Second, some aspects of program implementation were changed. A key change is that in lieu of using a 24 hour/7 days a week Interactive Voice Response System for round-the-clock verification for law enforcement and the public regarding the validity of the card, an internet-based system will be used. The on-going costs for maintaining this internet-based system is $10,152 annually.

The DHS states that they have drafted regulations, protocols, procedures, forms, scope of work for card production, and system requirements for the automated verification system and registry. It is anticipated that 5 pilot counties will be implemented on May 1, 2005 with two additional pilot counties operational by July 1, 2005. The remaining counties will be implemented beginning August 1, 2005.

Fees for the program will be collected from both patients and caregivers, as applicable. The fee will be about $13 per card for non-Medi-Cal eligible individuals and $6.50 for those individuals enrolled in Medi-Cal.

Background—Summary of SB 420: SB 420 requires a medical marijuana identification card to be issued to qualified patients and caregivers. Qualified patients are patients with acquired immune deficiency syndrome (AIDS), anorexia, arthritis, cachexia, cancer, chronic pain, glaucoma, migraine, seizures, severe nausea, persistent muscle spasms including those associated with, but not limited to, multiple sclerosis, and any other chronic condition that limits the person's ability to conduct one or more major life activities as defined in the Americans with Disabilities Act of 1990. In addition, SB 420 allows designated primary caregivers to possess or cultivate marijuana for medical use.

Subcommittee Staff Comment and Recommendation: No issues have been raised with this proposal. There is no General Fund support proposed for this program. It is recommended to approve as budgeted.

2. Implementation of Targeted Case Management for Tribal Organizations

Issue: The Subcommittee is in receipt of a Finance Letter to implement SB 308 (Figueroa), Statutes of 2003 which enables Native American groups to be considered "local government agencies" to participate in the Targeted Case Management (TCM) Program and Medi-Cal Administrative Activities (MAA). The Finance Letter requests an increase of $487,000 ($243,000 in Reimbursements from the Tribal Organizations and $244,000 in federal matching funds) to fund nine positions at the DHS. No General Fund support is requested.

The DHS states that there are a significant number to tribes who want to participate in the program. While that participation will take a while to grow, it is also a new constituency group, with new rules that need to be developed. Therefore, program development and implementation will need to take place. The DHS cannot just fold them into the existing TCM and MAA programs.

With respect to the requested 9 positions, the DHS requests to add 5 permanent positions as of July 1, 2005 to support the additional workload required by SB 308. The other 4 positions contained in the Finance Letter would be established as of June 30, 2006, only if justified by the workload. It is expected that the program will transition from development and training to implementation during 2005-06 and that the 9 total positions will be necessary by 2006-07.

The nine positions will provide additional resources to allow 20 percent of the 107 federally recognized tribes to participate in TCM and MAA. The DHS will need to phase in the 20 percent participation to enable development of the program , negotiation with the federal CMS and the Native Americans to develop the program guidelines, and develop training and provide technical assistance to accommodate the unique requirements of the Native Americans.

Background—TCM and MAA Programs: Under these programs, local government agencies and local education consortia can obtain federal matching funds through the Medi-Cal Program for certain activities. For MAA related activities, examples include: facilitating Medi-Cal application; contracting for Medi-Cal services; program planning and development; claims administration; certain types of training; and other various administrative activities. For TCM related activities, examples include: providing assistance for Medi-Cal enrollees to access needed medical, social, education and other services; conducting needs assessments; developing individualized service plans; crisis assistance planning; and related activities.

Background—SB 308, Statutes of 2003: This Legislation enables Native American tribes, tribal organizations, and tribal subgroups within the definition of a "local governmental agency" to contract for administrative and case management activities.

Subcommittee Staff Comment and Recommendation: The Finance Letter implements the legislation as required. No General Fund support is necessary. The Tribal organizations would benefit by obtaining the federal matching funds for these TCM and MAA services. The receipt of federal funds for these services is greater than the amount needed to reimburse for the positions. No issues have been raised.

B. Item 4280 Managed Risk Medical Insurance Board

I. BACKGROUND OVERALL

The Managed Risk Medical Insurance Board (MRMIB) administers programs, which provide health care coverage through private health plans to certain groups without health insurance. The MRMIB administers the: (1) Healthy Families Program, (2) Access for Infants and Mothers (AIM) and (3) Major Risk Medical Insurance Program.

The budget proposes total expenditures of $1.048 billion ($355.9 million General Fund, $620 million Federal Trust Fund, $1.7 million County Health Initiative Matching Funds, $40 million Major Risk Medical Insurance Fund, and $30.1 million in other funds) for *all* programs administered by the Managed Risk Medical Insurance Board.

Of the total amount, $9.3 million is for state operations.

This funding level represents an increase of 11.4 percent over the revised current-year. Most of this proposed net increase is due to increased enrollment into the Healthy Families Program. Significant adjustments are also proposed for the Access for Infants and Mothers (AIM) Program.

Summary of Expenditures (dollars in thousands)	**2004-05**	**2005-06**	**Dollar Change**	**Percent Change**
Program Source *(Local Assistance)*				
Major Risk Medical Insurance Program	$39,144	$39,144	--	--
Access for Infants & Mother	$123,176	$99,758	($23,418)	(19.0)
Healthy Families Program	$806,778	$894,948	$88,170	10.9
County Health Initiative Program	$5,489	$4,663	($826)	15.0
Unallocated Reduction—State Support	--	($937)	($937)	(100)
Totals Expenditures	**$974,587**	**$1,038,513**	**$63,926**	**11.4**
Fund Sources:				
General Fund	$303,286	$313,592	$10,306	3.4
Federal Funds	$617,860	$639,162	$21,302	3.4
County Health Initiative Matching Fund	$53,846	$53,846	--	--
Other Funds	$146,094	$149,707	$3,613	2.4
Total Funds	$1,121,086	$1,156,307	$35,221	3.1

C. ITEMS FOR DISCUSSION—Managed Risk Medical Insurance Board

1. Healthy Families Program Estimate—*ISSUES "A" to "D"*

Background—Overall on the HFP (See Hand Out): The Healthy Families Program (HFP) provides health, dental and vision coverage through managed care arrangements to uninsured children (through age 18) in families with incomes up to 250 percent of the federal poverty level, who are not eligible for Medi-Cal but meet citizenship or immigration requirements.

The benefit package is modeled after that offered to state employees. Eligibility is conducted on an annual basis.

In addition, infants born to mothers enrolled in the Access for Infants and Mothers (AIM) Program (200 percent of poverty to 300 percent of poverty) are immediately enrolled into the Healthy Families Program and can remain under the HFP until *at least* the age of two. If these AIM to HFP two-year olds have families that exceed the 250 percent income level, then they would no longer be eligible to remain in the HFP.

Summary of Eligibility for Healthy Families

Type of Enrollee	Family Income Level	Comment
AIM infants (born to AIM mothers)	200 % to 300 %	Up to 2-years only, if above 250 %. Otherwise, through age18.
Children 1 to 5 years of age	Above 133% to 250%	Children this age who are under 133% are eligible for Medi-Cal.
Children 6 years up through age 18.	101 % to 250%	Children this age who are 100% and below are eligible for Medi-Cal.
Some children enrolled in county "healthy kids" programs (AB 495 projects, discussed below)	250% to 300%	State provides federal S-CHIP funds to county projects as approved by MRMIB.

Families pay a monthly premium and copayments as applicable. The amount paid varies according to a family's income and the health plan selected. Families that select a health plan designated as a "community provider plan" receive a $3 discount per child on their monthly premiums.

The Budget Act of 2004 and accompanying trailer bill language increased the premiums paid by higher income families effective as of July 1, 2005. Specifically, as of July 1, 2005, families with incomes between 200 percent and 250 percent of poverty will pay $12 to $15 per child per month (currently it is $4 to $9 per child). The family maximum per month will be $45 (currently it is $27 per family) for these families.

Families below 200 percent of poverty pay premiums ranging from $4 to $9 per child per month, up to a family maximum of $27 per month. This premium level has not changed.

California receives an annual federal *allotment* of Title XXI funds (federal State-Children's Health Insurance Program) for the program for which the state must provide a 35 percent General Fund match. The federal allotment slightly varies contingent upon appropriation by Congress. This is *not* a federal entitlement program.

Background—Overall Governor's Proposed Budget: A total of $894.9 million ($325.2 million General Fund, $559.1 million Federal Title XXI Funds, $1 million Proposition 99 Funds, and $9.7 million in Reimbursements) is proposed for the HFP, excluding state administration. This reflects an increase of $88.2 million ($33.3 million General Fund) or 10.9 percent over the revised current-year.

The budget assumes a total enrollment of 789,301 children as of June 30, 2006, for an increase of 75,425 children over the revised current year enrollment level. This represents a budget year enrollment growth rate of 10.6 percent.

This projected enrollment growth rate reflects a higher growth trend due to the (1) proposed restoration of the HFP and Medi-Cal Application Assistance Program, (2) proposed changes to the Medi-Cal to HFP Bridge process, and (3) the shift of infants from the Access for Infants and Mothers (AIM) Program to the HFP.

The total enrollment figure of 789,301 children is based on the sum of five population segments as follows:

- Children in families up to 200 percent of poverty: 516,207
- Children in families between 201 to 250 percent of poverty: 190,775
- Children in families who are legal immigrants: 16,222
- Child Health Disability Prevention (CHDP) Gateway Access: 33,901
- Access for Infants and Mothers (AIM) Program shift 7,917

The Governor' budget assumes that payments to health, dental and vision plans remain unchanged from the Budget Act of 2004. However, it is likely that rate increases will be proposed at May Revision since the health plan contracts are opened for a reprocurement.

Presently, for children from one through 18 years the average cost is $91.46 per month for all benefits. For infants 0 to 1 years with family income between 200 percent and 250 percent of poverty the average cost is $214.99 per month for all benefits. For infants born to AIM moms who enrolled on or after July 1, 2004, a negotiated lump sum rate of $2,910 is used for the first two months of enrollment and then the HFP infant rate will be used for the remaining ten months.

(Issues "A" through "D' begin on the next page, below).

ISSUE "A"—Status Update on New Contracts *(Informational)*

Issue: On March 2, 2005, the MRMIB awarded new, three-year contracts for the delivery of health, dental and vision plan services for the Healthy Families Program for the period of July 1, 2005 through June 30, 2008.

With respect to these new contracts the following should be noted:

- 24 health plan contracts were selected.
- 7 dental plans were selected.
- 3 vision plans were selected.

The MRMIB notes that expenditure adjustments will be needed at the Governor's May Revision to reflect the new contract costs. According to the MRMIB, an overall net increase of 1.5 percent (in the aggregate) was approved.

Questions:

1. MRMIB, Please provide a brief summary of the revised contracts. Were there any key changes to the contract requirements? Why are fewer health care plans participating in this cycle?
2. MRMIB, Are there any coverage concerns geographically, or with the provision of specialty care services?

ISSUE "B"—Proposal to Re-Establish Outreach Activities

Issue: The budget proposes a total increase of $14.5 million ($6 million General Fund, $5.8 million federal funds, and $2.7 million in Reimbursements) to re-establish certain outreach activities to improve enrollment in both the HFP and Medi-Cal for Children programs. Prior to 2003, there had been an outreach program which was quite successful at enrolling children into these programs. Generally, this budget proposal would re-establish the same program framework as previously implemented. However, the HFP Administrative Vendor would be processing the payments under this proposal, whereas before, it was the Medi-Cal Program's fiscal intermediary.

In addition, as discussed further below, funds have been made available for this purpose through the WellPoint Health Networks and Anthem merger.

The specific program components and costs are as follows:

- ***State Administrative Support:*** An increase of $263,000 ($92,000 General Fund) to fund three new positions (one Office Technician, one Associate Governmental Program Analyst, and one Staff Services Manager II) is proposed.

  MRMIB states the positions are needed to: (1) Provide expertise in the development of business rules; (2) Test the Administrative Vendor system for operational readiness and accuracy of payments to Certified Application Assistors; (3) Oversee implementation and ongoing monitoring of the Administrative Vendor functions; and (4) Review and approve all outreach activities and promotional materials.

- ***Certified Application Assistance Fees:*** An increase of $11.8 million ($4.9 million General Fund) is proposed to: (1) Provide a $50 fee for each successfully enrolled HFP application upon request by a Certified Application Assistor; (2) Provide a $50 fee for each completed Medi-Cal application transmitted to a county upon request by a Certified Application Assistor; and (3) Provide a $25 fee for each successful annual eligibility redetermination for the HFP that results in ongoing coverage for an eligible child. These fees are at the same level as done under the prior outreach program.

  The proposed amount of $11.8 million (total funds) assumes the following:

  - 103,000 HFP applications at $50;
  - 106,000 Medi-Cal applications at $50; and
  - 51,600 are annual eligibility redeterminations for HFP at $25.

  The MRMIB notes that use of Certified Application Assistance is a time-tested method that has proven effective in ensuring that HFP/Medi-Cal for Children applicants are successful in enrolling and remaining in the programs.

- ***Additional Enrollees in the HFP:*** An increase of $2.4 million ($878,000 General Fund) is proposed to fund increased enrollment into the HFP of about 14,372 children (by June 30, 2006) attributable to the new outreach activities. This enrollment increase represents a 9 percent historical growth rate experienced just prior to elimination of the Certified Application Assistance funding.

According to the MRMIB and their tracking data, utilizing Certified Application Assistance significantly improves the completeness of applications and the success rate for enrollment into these programs. For example, they note the following:

- The number of incomplete applications has increased from 40 percent in 2003 to 70 percent now.
- Prior to the Certified Application Assistor's funding being eliminated the monthly average disenrollment for not returning the annual eligibility re-determination or not following up on an incomplete application was about 8,000 children. As of October 2004, the monthly average disenrollment was over 12,000 children (a 50 percent increase).
- Children are experiencing delays in obtaining health insurance coverage. The length of time it takes a child to be enrolled is much longer (about two months) because the Administrative Vendor must contact the applicant and collect information that is missing due to incomplete applications.
- There has been a dramatic increase in appeals (from 130 per month to over 600 per month) since the Certified Application Assistor's funding was eliminated.

Background—Previous Outreach Efforts: When the HFP was launched in July 1998, an outreach program for both the HFP and Medi-Cal for Children was implemented. This original outreach program included: (1) toll-free telephone access, (2) media campaigns, (3) local grants to community-based organizations and schools, and (4) payments to Certified Application Assistants for the successful enrollment of applicants. Program funding peaked at $50 million ($20 million General Fund) in 2001-02.

Due to funding constraints, the education and outreach expenditures and grants were eliminated in 2001, and funding for Certified Applicant Assistants was eliminated in 2003. The toll-free telephone access has always been maintained.

Background—Merger of WellPoint Health Networks and Anthem: As part of the agreement with Insurance Commissioner Garamendi, it was determined that Anthem, Incorporated would make certain donations to demonstrate their commitment to serve the uninsured and medically underserved in California. Among other donations, Anthem is to provide $15 million to the state for outreach and enrollment for the HFP and Medi-Cal for Children programs. These funds are to be placed in the General Fund and appropriated for this purpose. The state can then receive a federal match of 65 percent through federal S-CHIP funding.

Subcommittee Staff Comment and Recommendation: The outreach program has been successful in the past and funds from the merger have been made available for this purpose. It is therefore recommended to approve the proposal but with one change.

It is recommended to downgrade the Staff Services Manager II position to a Staff Services Manager I position for savings of $7,900 ($2,780 General Fund).

This is recommended as part of an overall approach to address the MRMIB's unallocated reduction of $937,000 ($328,000 General Fund), as discussed under Issue "D", below in the Agenda.

Questions:

1. MRMIB, Please provide a brief summary of the budget request.
2. MRMIB, When would the Certified Application Assistance component be operational?

ISSUE "C"—Medi-Cal to Healthy Families Accelerated Enrollment

Issue: In the Subcommittee hearing of April 4th during discussions regarding the "bridge" between Medi-Cal and the HFP, an issue was raised regarding the temporary enrollment of children into Medi-Cal pending their HFP eligibility.

Specifically, County Welfare Departments encounter children who are either not eligible for Medi-Cal or would have a high share-of-cost in Medi-Cal but would most likely be eligible for enrollment into the HFP. However presently, the counties cannot enroll these children into the HFP because they do not have the authority to do so. Therefore, these children often have to wait, uninsured, for 4 to 8 weeks for a formal eligibility determination by the HFP.

As such it has been suggested to create a Medi-Cal to HFP accelerated enrollment program which would authorize counties to temporarily enroll children into the **no-cost** Medi-Cal Program if a county deems that they are eligible for the HFP. The temporary enrollment would only be for the period during which the HFP is conducting the formal determination of the child's eligibility for that program (not more than 60-days).

Under such an accelerated program, the state could receive the S-CHIP federal matching rate of 65 percent, versus the Medi-Cal federal matching rate of 50 percent. Temporary enrollment into Medi-Cal would enable the child to receive immediate necessary services.

This issue has been discussed previously in legislation during the 2003-04 Session (i.e., SB 142, Alpert, as amended March 24, 2003). This legislation was discussed in both the Senate Health and Human Services Committee, as well as Senate Insurance and Senate Appropriations. Though the bill was moving it eventually was amended and used for another purpose.

A substantial effort has been made by the Legislature to create a seamless system of health care coverage, whereby individuals can move easily between Medi-Cal and the HFP without losing coverage for any period of time. A Medi-Cal to HFP accelerated enrollment would fill-in a present gap in services.

Subcommittee Staff Comment and Recommendation: Based on previous analyses of the SB 142 legislation, it appears this change would cost about $1.5 million (General Fund) *annually*, assuming the temporary enrollment of about 3,600 children. However, it is recommended to hold this issue "open" pending receipt of additional information to be provided by the MRMIB and DHS regarding potential expenditures.

According to prior information, it appears that the proposed change could be done through a State Plan Amendment and would not require substantial administrative work. Further, state statute would be needed for implementation. This language would be very similar to language contained in SB 142.

Questions:

1. MRMIB, From a "technical assistance" or policy basis, would this approach make sense?

ISSUE "D"—Request for New State Staff for Oversight of Contractor

Issue: The Governor proposes an increase of $2.2 million ($775,000 General Fund) to support 24.5 new state positions. The MRMIB contends these positions are needed to provide increased oversight of contractor and customer service functions. This reflects a 52 percent increase in positions over the revised current year.

In addition, the budget proposes an unallocated reduction of $937,000 ($328,000 General Fund) from state support. MRMIB states that 10 of the requested positions would need to be left unfunded and one other would need to be downgraded (from a Staff Services Manager II to I) in order to "fund" the unallocated reduction. This is shown in the table below.

Presently, MMRIB has 62.7 total authorized positions in the current year (includes three positions administratively established for the "buy-in", Agenda Item 2, below). Presently there are 9 vacant positions, of which 3 are to be filled by May, 2005.

Summary Table 1: Budget Request & Unallocated Reduction Interaction

MRMIB Function	MRMIB's Requested Positions	MRMIB's Estimate of Unallocated Reduction	Actual Funded Positions
• On-Site Administrative Vendor Coordination & Quality Assurance	8.0 Positions	-2.0 Positions	6.0 Positions
• Application & Subscriber Complaints and Appeals	8.0 Positions	-4.0 Positions	4.0 Positions
• Contract & Fiscal Management of Program Expenditures	5.5 Positions	-3.0 Positions	2.5 Positions
• Executive Management Structure	3.0 Positions	-1.0 Positions	2.0 Positions
Total Positions	**24.5 Requested**	**-10.0 Deleted ($328,000 GF)**	**14.5 Positions**

The following discussion outlines the MRMIB's 24.5 new positions request by "function" area.

On-Site Administrative Vendor Coordination & Quality Assurance: MRMIB notes that recent experience with Administrative Vendor (Maximus) errors and lack of adequate oversight indicates that MRMIB is not adequately providing the core oversight needed at its Administrative Vendor site. MRMIB currently has no dedicated staff to monitor the Administrative Vendor *at its site*.

Therefore, the MRMIB is requesting the following 8 positions:

- 6 Associate Governmental Program Analysts;
- One Staff Services Manager II; and
- One Office Technician

According to the MRMIB, these positions would perform the following core tasks:

- Detect billing errors, disenrollments and application processing system problems in a timely fashion and address them before costly errors occur.
- Provide adequate quality control and oversight of the Administrative Vendor.
- Conduct activities to ensure that eligibility determinations are being done correctly.

Application & Subscriber Complaints and Appeals: MRMIB presently has 8 positions that perform functions related to eligibility appeals and subscriber complaints. They used to have a total of 16 positions; however the MRMIB states that 8 positions were eliminated over the past two years due to unallocated reductions in state support.

MRMIB notes there is a backlog in appeals (1,000) and that the appeal rate for "ineligible" determinations is high.

The requested 8 positions (all Associate Governmental Program Analysts) would be used to do the following:

- Respond timely to appeals from applicants, subscribers and advocates;
- Resolve misdirected provider claims and address overall provider inquiries;
- Follow up on third party liability issues; and
- Respond to public record requests.

Contract & Fiscal Management of Program Expenditures: MRMIB is requesting 5.5 positions (2.5 Associate Administrative Analysts for Accounting, one Associate Governmental Program Analyst, one Associate Programmer Analyst, and one Research Program Specialist I) for this function.

MRMIB contends that with cutbacks in state staff they have not been able to effectively and consistently monitor the performance of contracting health, dental and vision plans. Each year the MRMIB audits each plan for their loss ratios to determine if rates are set appropriately. MRMIB states that in the past, only a third of the plans have been audited and at most only one plan could be audited in the current year due to staff shortages. In addition, MRMIB uses loss ratios as a tool for diagnosing performance problems of plans. Of the total requested positions, 4.5 positions would be used for this purpose.

The requested Research Program Specialist I position would be used to develop research protocols and statistical reports to provide MRMIB with information necessary to evaluate and measure progress towards federal and state quality improvement goals.

Executive Management Structure: MRMIB is requesting three positions (one Deputy Director—CEA II, one Associate Governmental Program Analyst), and one Staff Counsel III for certain functions.

The Deputy Director (CEA II) position would be used to manage press inquires, work with the CHHS Agency and Governor's Office on press events and coordinate MRMIB's responses to legislation.

The Associate Governmental Program Analyst would be used to provide technical support to the legislative unit. The legislative unit has a Legislative Coordinator positions presently but no other staff.

The Staff Counsel III position would be used to (1) review and approve contracts, (2) review public record act requests and subpoenas, (3) conduct legal analyses of federal and state legislation and regulations, (4) conduct legal research and perform activities related to the Health Insurance Portability and Accountability Act, (5) document and formalize legal advice for executive and program staff, and (6) handle legal complaints arising from protected health information disclosures or the withholding of such information

Legislative Analyst's Office Recommendation: The LAO's recommendation would be to take the following actions, for a net overall reduction of $84,000 ($29,000 General Fund) and an increase of 13.5 positions:

- Eliminate the MRMIB's unallocated reduction of $937,000 ($328,000 General Fund);
- Delete two of the positions proposed for the executive management infrastructure.
- Shift two of the Associate Governmental Program Analyst positions requested for the on-site Administrative Vendor coordination & quality assurance function to work on the contract and fiscal management function. This would provide a total of 4.5 positions for the contract and fiscal management function, and four positions for the on-site Administrative Vendor coordination & quality assurance function.
- Downgrade one of the Staff Services Manager II positions to Staff Services Manager I position, as the MRMIB noted for helping to "fund" a portion of the unallocated reduction.

Subcommittee Staff Comment and Recommendation: Due to concerns with the Administrative Vendor, the need to respond to consumer (applicant and subscribers) and provider inquiries on a timely basis, and the need to properly and effectively monitor fiscal oversight of the program, it is reasonable for the MRMIB to receive some additional positions. However, in addition to the state's fiscal situation, there are also other factors that need to be considered with this request.

First, the re-establishment of the Certified Application Assistance process will significantly improve the application processing and reduce the number of appeals. The three positions proposed under this request will also provide some oversight of the Administrative Vendor.

Second, funding and positions should not be appropriated to then use to "fund" the unallocated reduction. This approach denigrates the budget process and leads to false representation as to positions actually available to be filled and funded. Legislative oversight is significantly weakened by this approach proposed by the Administration.

Third, if problems persist regarding the Administrative Vendor, the Board should consider making changes in the contract to require *additional* performance measures.

Fourth, two of the "executive management structure" positions are not warranted. Specifically, the Deputy Director (CEA II) position to perform primarily press-related activities, and the Associate Governmental Analyst for the legislative unit should be deleted.

Therefore, it is recommended to (1) provide an increase of $930,000 ($325,000 General Fund) to eliminate the unallocated reduction (adjusted for the downgraded position), (2) provide funding for 7.5 new positions as noted in the table below, and (3) reduce the budget by a *net* $ 594,000 ($208,000 General Fund) to reflect these actions.

The Table 2 presents a summary of the recommendations. It should be noted that the MRMIB wants all of the requested 24.5 positions ($2.215 million total funds) but could only fund 14.5 of them due to the unallocated reduction proposed by the Governor (Summary Table 1, above, depicts this aspect).

Summary Table 2: Perspectives on the Requested Positions

MRMIB Function & Positions	Positions Adjusted for Unallocated	LAO Recommendation	Subcommittee Staff
On-Site Administrative Vendor Oversight	6.0 Positions	4 Positions	2 Positions
Downgrade SSMII to SMMI	1	1	--
Associate Governmental Prog. Analysts	4	2	2
Office Technician	1	1	--
Application & Subscriber Appeals	4.0 Positions	4 Positions	2 Positions
Associate Governmental Prog. Analysts			
Contract & Fiscal Management	2.5 Positions	4.5 Positions	2.5 Positions
Associate Administrative Analysts	1.5	1.5	1.5
Associate Governmental Prog. Analysts	--	2	--
Research Program Specialist I	1	1	1
Executive Management Structure	2.0 Positions	1 Position	1 Position
Deputy Director (CEA II)	--	--	--
Staff Counsel III	1	1	1
Associate Governmental Prog. Analyst	1	--	--
Total Positions	**14.5 Positions**	**13.5 Positions**	**7.5 Positions**
Total Proposed Expenditure (Adjusted for Unallocated Reduction)	**$1.287 million ($450,000 GF)**	**$1.226 million ($430,000 GF)**	**$693,000 ($243,000 GF)**
Total Proposed Savings off Budget	**$0**	**$60,000 ($22,000 GF)**	**$594,000 ($208,000 GF)**

Questions:

1. MRMIB, Please provide a brief summary of the budget request by function area.

2. County Health Initiative Matching Fund (CHIM) Program

Issue: The budget proposes to provide a total of $5.5 million ($1.9 million County Health Initiative Matching Fund and $3.6 million federal S-CHIP Funds) in the current year and $4.7 million ($1.6 million County Health Initiative Matching Fund and $3 million federal S-CHIP Funds) in 2005-06 under the CHIM Program. These funding levels represent a substantial reduction in anticipated funding levels as compared to the Budget Act of 2004.

The Budget Act of 2004 appropriated a total of $115.1 million ($40.3 million County Health Initiative Matching Fund and $74.8 million federal S-CHIP Funds). This funding request included funding for four counties that were included in the initial State Plan Amendment approved in June, 2004. These counties were: Alameda, San Francisco, San Mateo and Santa Clara.

According to the MRMIB, the reason for the reduced funding level is that the caseload has not yet materialized from the counties.

Background—County Health Initiative Matching Fund (CHIM) Program: AB 495, Statutes of 2001, allow county governments and public entities to provide local matching funds to draw down federal S-CHIP funds for their Healthy Kids Programs (i.e., children 250 to 300 percent of poverty who are citizens). The State Plan Amendment approved by the federal CMS provided for four pilot counties (i.e., Alameda, San Francisco, San Mateo, and Santa Clara) with a phase-in of additional counties (i.e., Santa Cruz and Tulare) in 2005-06.

Subcommittee Staff Comment and Recommendation: The proposed budget reflects a revised estimate for the CHIM Program. Specifically, the MRMIB assumes an enrollment level of 3,820 children as follows:

- Alameda = 265children
- San Mateo = 278 children
- San Francisco = 1,209 children
- Santa Clara = 954 children
- Santa Cruz = 164 children
- Tulare = 950 children

No issues have been raised. It is recommended to approve as budgeted.

Questions:

1. MRMIB, Please provide a brief description of the budget request.

3. HFP Linkage with County "Healthy Kids" Programs Through "Buy-In" *(See Hand Out)*

Issues: The budget proposes (1) an increase of $261,000 ($91,000 Proposition 10 Funds and $170,000 federal funds) to fund three two-year limited-term positions at MRMIB, and (2) trailer bill legislation to develop an HFP "buy-in" option. The three positions include an Office Technician, a Research Program Specialist I, and a Staff Services Manager I. No General Fund support is requested.

Under this proposal the MRMIB would use staff to provide technical assistance and support to local counties in the development and expansion of their locally funded "Healthy Kids Programs" and to work with interested counties to develop an HFP "buy-in" option. As discussed below, while some counties have implemented their own Healthy Kids Programs, other counties may like to use their local funds to "buy-in" to the HFP directly.

In essence, this "buy-in" proposal is a subset of the overall existing County Health Initiative Matching Fund (CHIM) Program (as discussed above).

The proposed staff would determine how the "buy-in" concept should be designed and would work with county staff to implement any of the approved "buy-in" programs.

The proposed trailer bill language does the following (See Hand Out):

- ***Section 3:*** Deletes obsolete language which granted the Board authority to contract with county-based plans that were either not licensed or not fully licensed. This language was applicable to the HFP when initially implemented but is now obsolete and is inconsistent with the Board's current contracting practices which require health plans to be licensed by the Department of Managed Care (DMHC) or the Department of Insurance (DOI).
- ***Section 4:*** Amends existing statute to include the HFP "buy-in" option as part of the overall County Health Initiative Matching Fund projects.
- ***Section 5 (Section 12699.53 (b)):*** Amends existing statute to clarify that the "applicant" (county) for the intergovernmental transfer funding (federal S-CHIP funds transferred by the state to a county) must comply with requirements as stated.
- ***Section 5 (Section 12699.53 (g)):*** Adds a new provision that provides for the "buy-in" and specifies that approved applicant's must provide for children's health coverage through the health, dental and vision plans participating in the HFP.
- ***Section 6:*** Makes technical conforming changes.
- ***Section 7:*** Adds a new provision that provides for the MRMIB to be reimbursed by applicants (counties) for any reasonable start-up costs, ongoing administrative costs and related expenditures that are not reimbursed by the federal government for the operation of this program.

- ***Section 8:*** Amends existing statute to clarify that HFP "buy-in" projects must use health plans licensed by the DMHC or DOI.
- ***Section 9:*** Amends existing statute to enable MRMIB administrative expenditures, as stated, to be paid by a governmental entity participating in the HFP "buy-in" or by a not-for-profit group or foundation.
- ***Section 10:*** Amends existing statute to hold the state harmless for any federal disallowances or other liabilities as specified, including HFP "buy-in" grant appeals.

Background—County Healthy Kids Programs: Several counties have established or are planning to establish programs to provide coverage to uninsured children who are not eligible for full-scope coverage under Medi-Cal or the HFP. Funding for this county coverage has come from a variety of sources, including local Proposition 10 funds, county Tobacco Settlement Funds, grants from foundations, and federal funds obtained from the MRMIB through the County Health Initiative Matching Fund (CHIM) Program established by AB 495, Statutes of 2001. Counties with Healthy Kids programs include Santa Clara, Alameda, San Francisco, San Mateo, San Joaquin, San Bernardino, Riverside, Santa Cruz, Tulare, and Los Angeles.

Other counties are interested but either require technical assistance in developing their own programs or would simply like to use local funds to "buy-in" to the Healthy Families Program.

Subcommittee Staff Comment and Recommendation: It is recommended to approve the budget and trailer bill legislation as proposed. The California Children and Families First Commission has approved funding for the MRMIB to work with the counties to develop the "buy-in" option. The "buy-in" would enable counties to utilize the advantages of the HFP marketplace and it would provide comprehensive health care to children in need of medical services.

Questions:

1. MRMIB, Please provide a brief description of the HFP "buy-in" concept, including a summary of the proposed trailer bill legislation.
2. MRMIB, What is the estimated timeframe for proceeding with the HFP "buy-in", including obtaining federal approvals?

D. ITEMS FOR DISCUSSION—Department of Health Services

1. Proposition 50—Request for Staff Due to Workload *(See Hand Out)*

Issue: The Subcommittee is in receipt of a Finance Letter which requests an increase of $761,000 (Proposition 50 Bond Funds) to support 7 new, two-year limited-term, positions (six Associate Sanitary Engineers and one Environmental Scientist). The DHS states these positions are needed in order to meet workload needs related to Chapter 4 mandates as contained in Proposition 50 (see background below).

Presently the DHS utilizes 13.5 positions for Chapter 4 activities at an expenditure of $1.8 million (Proposition 50 Bond Funds). Adding these proposed 7 positions (two-year limited-term) would provide them with a total of 20.5 positions at an expenditure level of about $2.5 million (Proposition 50 Bond Funds) for 2005-06.

The DHS required water systems to submit "pre-applications" for Proposition 50 funding by December 1, 2004. By this date, 920 pre-applications had been received. The DHS then needs to review and rank the proposals. Once this is done, full applications with technical detail are submitted by the water systems. As such, the DHS states that additional resources are needed to conduct various complex analyses and work with the water systems to implement the various projects and fully utilize the bond funds.

The DHS contends that if this Finance Letter is approved, they will be able to fully commit the Proposition 50 Bond Funds within 6 to 10 years. Without these positions, the process will be substantially delayed and funds wouldn't be committed for at least 15 years.

Background on Proposition 50 and Chapters Applicable to the DHS: Proposition 50—the Water Security, Clean Drinking Water, Coastal and Beach Protection Act of 2002—was approved by the voters to provide $3.4 billion in funds to the consortium of state agencies and departments to address a wide continuum of water quality issues. The bond measure contains 11 chapters, or subdivisions, which delineates the funding level to be provided over the course of the bond and the activities and functions which are to be addressed.

Several chapters within the Proposition 50 Bond measure pertain to functions conducted by the DHS as it pertains to the Drinking Water Program, including Chapter 3 and Chapter 4. The DHS anticipates receiving as much as $485million over the course of the bond measure. This funding is discussed below.

Background on Chapter 4—Safe Drinking Water: Proposition 50 provides that $435 million be available to the DHS for expenditure for grants and loans for infrastructure improvements, and related actions to meet safe drinking water standards.

About $100 million will be used as the state's matching funds to access the federal capitalization grants for public water system infrastructure improvements. These state matching funds will be spent over 6 years and will draw down an additional $85 million (federal funds) for the 6 year period. These funds are expended through the Safe Drinking Water State Revolving Fund Program.

Of the remaining funds, $261 million in grants is directed to Southern California water agencies to reduce their reliance on water from the Colorado River. California has exceeded the water rights it is entitled to from the Colorado River and therefore must reduce its use of this source to 4.4 million acre feet.

The remaining $70 million in grants is to be divided into five general categories to improve water quality. These categories include improvements to: (1) drinking water sources; (2) treatment facilities for contaminant reduction/removal; (3) monitoring facilities; (4) transmission and distribution infrastructure; and (5) meeting new federal rules such as the disinfection-by-products rule.

Background on Chapter 3—Water Security: Proposition 50 provides a total of $50 million for functions that pertain to water security, including the following: (1) Monitoring and early warning systems; (2) fencing; (3) protective structures; (4) contamination treatment facilities; (5) emergency interconnections; (6) communications systems; and (7) other projects designed to prevent damage to water treatment, distribution, and supply facilities.

Background—Safe Drinking Water State Revolving Fund Program: Senate Bill 1307, Statutes of 1998, enacted the Safe Drinking Water State Revolving Fund. It established the framework to implement the Safe Drinking Water State Revolving Fund (SDWSRF) and authorized the DHS to enter into assistance agreements for capitalization grants with the federal government. These state matching funds will be spent over 6 years and will draw down an additional $85 million (federal funds) for the 6 year period.

The SDWSRF provides subsidized funding to Public Water Systems so that they can make needed improvements to water system infrastructure to eliminate deficiencies in water treatment, storage and delivery that put consumers at risk of waterborne illnesses.

Subcommittee Staff Comment and Recommendation: The requested 7 new, two-year limited-term positions, seem reasonable due to the workload and substantial technical analyses that are needed to appropriately allocate and expend Proposition 50 Bond funds. No issues have been raised.

Questions:

1. DHS, Please provide a brief update on the status of Proposition 50 implementation as it pertains to Chapter 4 activities.
2. DHS, Please describe the budget request and need for the positions.

2. Proposition 50—Request for CA Bay-Delta Authority Funding

Issue: The DHS proposes an increase of $125,000 (Proposition 50 Bond Funds) to fund a position at the California Bay –Delta Authority (CBDA) provided through an interagency agreement. The DHS states that the CBDA subcontracts with the Santa Clara Valley Water District for a "Water Quality Program Manager" who oversees and coordinates the Drinking Water Quality Improvement Program for the DHS.

It should be noted that this activity is funded in the current year with one-time only funds (Proposition 50 Bond Funds) that were available due to delays in hiring DHS staff in the current year. However the DHS notes that all staff have now been hired so in order to continue this subcontract, an appropriation is needed for the budget year.

Senate Bill 1654 (Costa), Statutes of 2003, requires the DHS, a participating member of the CA Bay-Delta Program, to develop a water quality program. Resources were not provided to the DHS to carry out this program. As such, the DHS has an interagency agreement with the CBDA for this purpose.

The position will primarily be used to coordinate a variety of water quality projects proposed for funding under Proposition 50 Bond Funds that are in the CA Bay-Delta Program solution area to ensure that they are consistent with the "Record of Decision". (Among other things, the Record of Decision lays out the roles and responsibilities of each participating agency in CAL-FED, sets goals for the program and types of projects to be pursued)

Subcommittee Staff Comment and Recommendation: It is recommended to approve this request as budgeted.

Questions:

1. DHS, Please provide a brief summary of the budget request, including a description as to how the position will be used by the CBDA.

3. Capacity Development for Small Water Systems

Issue: The DHS requests an increase of $400,000 (Water System Reliability Account Funds) to fund three contract positions for technical assistance for the Capacity Development Program within the Safe Drinking Water State Revolving Fund Program (SDWSRF Program). According to the DHS, there are presently two DHS positions used for the Capacity Development Program and more resources are needed to meet workload demands.

There are about 5,000 Small Drinking Water systems in California that serve less than 1,000 persons. Without additional support, the DHS states that many of these systems would not be able to comply with the numerous and technically complex federal and state requirements that are necessary to secure funding to achieve a safe drinking water supply.

They note that about 1, 257 Small Drinking Water systems are currently listed on the DHS' Project Priority List and have submitted pre-applications for 2,070 projects to potentially receive funds from the SDWSRF Program.

Among other things the $400,000 in contract positions would be used to do the following:

- Provide technical assistance to Small Water Systems for capacity development including conducting physical, operational, managerial, and financial assessments;
- Assist Small Water Systems to obtain funding for infrastructure improvements;
- Provide guidance to document compliance with CEQA;
- Assist in completing operational plans and emergency response plans;
- Coordinate co-funding projects with other funding agencies;
- Provide technical information to various stakeholders; and
- Assist in consolidating Small Water Systems into more viable systems.

The federal government allows for funds to be used for technical assistance.

Background—Safe Drinking Water State Revolving Fund Program: Senate Bill 1307, Statutes of 1998, enacted the Safe Drinking Water State Revolving Fund. It established the framework to implement the Safe Drinking Water State Revolving Fund (SDWSRF) and authorized the DHS to enter into assistance agreements for capitalization grants with the federal government. In order to draw down these federal capitalization grants, the state must provide a 20 percent match. This state match is provided using Proposition 50 Bond Funds, as discussed under Agenda, item one, above.

The SDWSRF provides subsidized funding to Public Water Systems so that they can make needed improvements to water system infrastructure to eliminate deficiencies in water treatment, storage and delivery that put consumers at risk of waterborne illnesses.

The SDWSRF Program includes *four set-aside funds* that are all supported by the federal capitalization grant and loan fund. The Water Systems Reliability Account is one of

these funds. The federal government allows states to use up to 10 percent of the annual federal capitalization grants to provide technical assistance to Public Water Systems.

Subcommittee Staff Comment and Recommendation: The DHS states that due to the technical nature of the work to be completed, they sometimes use an "interagency" agreement process to contract with another governmental entity, such as the UC system. However in discussions with the DHS they note that if an interagency agreement cannot be completed for the work, they *may* need to proceed with a Request for Application process and competitively bid for a contract.

Therefore, in order to avoid any potential legal issues regarding the use of state staff, it is recommended to adopt Budget Bill Language which enables the DHS to use these funds only for an interagency agreement, and not for contract staff. The recommended Budget Bill Language is as follows:

> Of the amount appropriated in this Item, up to $400,000 shall be used for an interagency-agreement to conduct work related to small drinking water systems. The funds shall not be used for any other purpose.

Questions:

1. DHS, Please describe the budget request and why contract funds are needed?

4. Home Medical Device Retailer Facilities

Issue: The Subcommittee is in receipt of a Finance Letter in which the DHS is seeking an increase of almost $1.2 million (Drug and Device Safety Fund) to fund 11 new positions (9 Senior Food & Drug Investigators and two Supervising Food & Drug Investigators). There are currently three positions used for this purpose.

According to the DHS, about 2,000 Home Medical Device Retailer facilities (retailers of prescription medical oxygen and medical equipment) must be inspected annually and licensed. The DHS contends they are understaffed to perform these functions and have a backlog of over 200 new license applicants. Only 20 percent of the state mandated inspections of these facilities can be conducted at the current staffing levels.

Effective January 1, 2002, the DHS was required to inspect and license Home Medical Device Retailer facilities (per AB 1496, Statutes of 2000). Specifically, the DHS must inspect all new drug and medical device manufacturers before a license can be issued. Thereafter, the DHS must do an inspection every two-years for license renewals.

Legislation created a special fund and established the Home Medical Device Retailers Licensing Program. The special fund combines licensing fees from three program areas—drug safety, medical device safety, and home medical device retailers. The fees paid by Home Medical Device Retailers are noted below. *No* fee increases are being proposed.

Home Medical Device Retailer Program

Type of Fee	2005 Fee
Exemptee Applicant Fee (one time, new)	$100
Exemptee Annual License Fee	$150
Home Medical Device Retailer Warehouses	$425
Out of State Facilities	$150
Home Medical Device Retailer (new & renewals)	$850

(To sell prescription products, a Home Medical Device Retailer facility must have a knowledgeable and trained person on site whenever they are open. This person is called an "exemptee".)

It should be noted that the DHS enrolled bill analysis for the legislation did identify a need of 15 positions at a cost of $1.4 million. Therefore, their budget request is consistent with their previous analysis of workload impact.

Subcommittee Staff Comment and Recommendation: The budget is consistent with the DHS enrolled bill analysis regarding the legislation. AB 1496 established fees that would fun ongoing program costs, and includes provisions to annually adjust fees, to assure that fees cover actual program costs. No issues have been raised. Therefore, it is recommended to approve as budgeted.

Questions:

1. DHS, Please provide a brief summary of the budget request.

5. Clinical Laboratory Improvement Fund—Fund Existing Positions

Issue: The Subcommittee is in receipt of a Finance Letter in which the DHS requests an increase of $644,000 (Clinical Laboratory Improvement Fund) to fund 8 *existing* positions (three Program Technicians, four Examiner I, and one Examiner II). Presently the DHS has 56 authorized positions in this area and of these, 45 are presently filled.

The requested $644,000 (Clinical Laboratory Improvement Fund) would fill 8 vacant positions to bring the total to 53 funded positions.

The DHS is requesting to fund these 8 positions in order to conduct work related to the following:

- *Medi-Cal Contract Support:* Two of the requested positions would be used to (1) conduct onsite audits of Medi-Cal laboratories and take enforcement action for those not complying with state and federal law, (2) process and review Medi-Cal applications, and (3) consult with the laboratories on Medi-Cal billing issues. Presently three positions are used for these purposes.

- *Phlebotomy Certification:* Four of the requested positions would be used to handle workload associated with this certification. The DHS anticipates that 25,000 people will be either certified or seeking certification in 2005-06. Presently four positions conduct these and related activities. Therefore, the request would double the DHS' workload capacity.

- *Genetic Scientist Licensure:* Recent legislation enacted in 2003 requires genetic scientist licensure. The DHS states that two staff were redirected to this effort after filing of emergency regulations. Currently 500 license applications and renewals are in process and are expected to bring in revenue of about $37,000. This revenue is expected to increase as the number of genetic scientists level off at about 1,000. The DHS is seeking to fund two positions to conduct these activities with the understanding that this program will not be totally fee supported for three to five years.

Further, the DHS notes that a laboratory cannot legally operate without a state license and a person cannot be legally employed in a laboratory without a license.

Subcommittee Staff Comment and Recommendation: According the DHS, fee revenues are available to support the additional staff. Additional staff have been needed in this area to address issues regarding the timely licensing of individuals and facilities. No issues have been raised.

Questions:

1. DHS, Please explain your budget request and the need for the positions.

6. Continuation of Pilots—AB 359 (Aroner), Statutes of 1999 *(See Hand Out)*

Issue: The budget proposes to (1) continue four positions (two-year limited-term) at the DHS, and (2) extend the existing Intermediate Care—Developmentally Disabled/Continuous Nursing (ICF-DD/CN) pilots for two more years through trailer bill legislation (January 1, 2006 to January 1, 2008). It should be noted that these positions as well as the legislation have both been extended once before (two year period the last time as well) through the budget process.

The budget proposes an increase of $196,000 ($76,000 General Fund) for continuation of the positions (January 1, 2006 to January 1, 2008). The positions are presently filled and working on this project.

As with all Waivers, this Waiver is required to demonstrate federal cost neutrality. According to the DHS, as more recipients are moved t pilot facilities from higher cost facilities such as hospitals, Developmental Centers, and Subacute facilities, the Waiver is showing cost neutrality and savings to the state. For the period of October 1, 2003 through March 31, 2004, with an average of 32 beds filled, the ICF-DD/CN Pilot Project achieved about $850,000 in savings, which should increase with the closure of Developmental Centers.

Background—AB 359 (Aroner), Statutes of 1999: This legislation required the DHS to institute a Waiver pilot program to provide continuous, 24-hour skilled nursing care to medically fragile persons with developmental disabilities in Waiver facilities—ICF-DD/CNs—as a Medi-Cal benefit. The goal of the pilot program is to explore licensure of a less restrictive health facility model for providing continuous skilled nursing for this population. The ICF-DD/CN services are being provided in small, home-like, community-based residential settings.

This ICF/DD-CN pilot program began enrolling recipients on April 3, 2002. The pilots presently have an expiration date of January 1, 2006. This sunset date was adjusted through the omnibus health trailer bill that accompanied the Budget Act of 2002. The date was moved back due to the late start in getting the pilots designed and implemented.

Background—Evaluation of the ICF-DD/CN Pilot Project: A recent evaluation conducted by researcher nurses at California State University at Sacramento (CSUS) found the projects overall to be a useful model to continue.

Subcommittee Staff Recommendation: It is recommended to approve the budget proposal and trailer bill language as proposed.

Questions:

1. DHS, Please describe the ICF-DD/CN Pilot Projects and the results from the evaluation.
2. DHS, Please describe the budget request and need for the positions.